**Testimony to the Insurance and Real Estate Committee on HB5042 and SB10** concerning the governor's budget and suggested supporting legislation from Maggie Goodwin a retire white haired social work from West Haven Ct who once mistakenly worker for a managed care company for two years.

As I read it, these two bills seem to empower the Office of Health Care Strategies (OHS) to seek private insurance companies and/DSS(Medicaid) to direct them to use what I would call a "capitated" payment system rather **than the more patient empowering fee for service payment system used currently in all primary care in CT.**

This "truncated", "capitated,"' "risk shifting" payment method would have primary care providers choose to include me in their practice as a patient for a **set amount of money** for **a set period of time**. During that timeframe the primary care doctor would not get any more money or any less money than the **set fee** payment **regardless** of the type or amount of care and attention I receive from the primary care practice. To me that means that my primary care doctor is initially going to have to make a financial risk management decision before accepting me as a patient and then during the set time period billed for would have to make repeated financial decisions about what amount and type of medical care I will receive. In addition, I will be strongly pressured to attend or participate in certain activities ( ie have a telehealth meeting with someone in the office or do a weekly wellness check because I am 72 and a fall risk, go to the gym).. The office staff rather than billing services will be monitoring and reporting my compliance with prescribed activities and monitor how much time the doctor is spending with me, what tests and referrals are being made while recording my "health outcomes" as all these things will be used for future documentation for rate cost cutting. I also project as a patient that my health outcomes would be used for my primary care doctor to discontinue me as patient if I am too sick. **I believe such payment per patient per set time frame will require primary care providers to constantly consider cost and not just medical necessity as the major if not their primary consideration when providing medical treatment to me**. It is not to my advantage as patient to have my primary doctors to be doing on going "risk analysis" of cost while treating me. His could happen if this legislation is voted out of committee.

It also appears that the OHS is redefining "Primay Care" in this legislation and that definition **excludes** certain medical providers because of their "specialty" like gynecologists' regardless where they are located, who their client population is and/or why as the patient I decided to access their services. So if these new definitions in this legislation are accepted it means to me as a woman I can not choose to go to my gynecologist for any "primary care services" and she cannot be considered my primary care doctor. I also question if I can be required to only go to my primary care doctor when I know I am sick but don't know what is wrong and I don't feel the primary care doctor is the best professional to attend to my needs at that particular time.

It seems too that the legislation is promoting a system that requires once the primary care doctor is selected and **is on my insurance card ,** I have to deal with them and they are stuck with me. It outlines in detail that if I want to leave the truncated rate practice and go to someone else, I will be given a phone number to go through a process of finding another primary care doctor who is approved by my insurance company or Medicaid but is also approved by OHS. It seems I cannot just call another doctor who is taking new patients and accepts my insurance because I **as the patient I am trapped** at least for a period of time with my primary care doctor and she is trapped with me until the time period paid for by the truncated rate is over. I am also concerned in such a capitated payment system my current primary doctor or a new one would refuse to accept me into the practice or retain me because of "my preexisting conditions" and my high volume use of primary care services.

Because I worked in managed care in DC some years ago and I have been a social worker and health care advocate for many years, I do not believe that private insurance companies, and those patients who are fortunate to have private insurance nor the doctors who serve that private insurance population will voluntarily participate in such a program that would be made possible in my opinion by this legislation. What makes this white haired retired social worker concerned though is if I am wrong and they do join a capitated rate primary care program or if such a program will be advocated for by the OHS and accepted by DSS for those CT residents on Medicaid.. If this legislation is passed and the Office of Health Care strategies and DSS approves this alternative to fee for service billing for primary care, many people just like me but with a little less money will be voicing the same concerns that I am bringing up today.

**Please do NOT pass this legislation (SB15 or HB5042) out of committee at this time. T**ake some more time to review what this legislation might enable and how the power granted in this legislation to the administrative branch might be misused and disruptive. Talk with those on HUSKY/Medicaid, the BIPOC community, the elderly like myself, those with complex health conditions and disabilities and low income individuals and families to get their input. We are just coming out of a pandemic and none of us need to experiment with our primary care health provision system in 2022.

**Again, I urge you to PLEASE VOYE against SB15 and or HB 5042. It could create a REAL MESS in PRIMARY CARE going forward and I urge you to get more information before taking this leap.**